Short Term Disability Claim Form Packet

This is a six part packet:

Used by employees, who are enrolled in Short Term Disability, to file a claim for compensation. It is the responsibility of the employee to ensure all portions are completed accurately.

If you are an employee of the Sheriff's Office, MIHS or Human Services please contact your HR office directly for Short Term Disability paperwork.

Employees of all other departments should return completed claims to:

Total Compensation Disability Management,
301 W. Jefferson, Suite #160
Phoenix, AZ 85003

Fax (602) 372-8574

Contact Disability Management at (602) 506-1010 press option 2 for Benefits, then option 3 for assistance in completing this form.

Refer to the Short Term Disability Booklet for information about the benefit.

Maricopa County

Total Compensation

Maricopa County
Total Compensation
301 W. Jefferson St, Ste 160
Phoenix, Arizona 85003
Phone: (602) 506-1010
Fax: (602) 372-8574

To: **Short-Term Disability Applicant**

From: **Total Compensation Department, Disability Management**

Enclosed you will find the Summary Plan Document that explains your Short-Term Disability benefit, a claim form with instructions for filing a claim, an Authorization and Agreement form and a Notification to Use Short-Term Disability in Lieu of PTO form.

The claim form contains three sections. The **Employee's** Statement is to be completed by you; the **Employer's** Statement is to be completed by your last assigned department's authorized individual; and the **Physician's** Statement is to be completed by the primary doctor responsible for your treatment. Your physician may also require that you complete a separate Authorization form.

You are responsible for ensuring that all three sections of the claim form, the Authorization and Agreement form and the Notification to use Short-Term Disability in Lieu of PTO form are completed in a timely manner and mailed or faxed to:

Maricopa County Total Compensation Department
Disability Management Unit
Attention: Intake Coordinator
301 W. Jefferson Street, Suite #160
Phoenix, AZ 85003
or fax to (602) 372-8574

You should also provide a copy of the Notification to use Short-Term Disability in Lieu of PTO form to your Payroll or HR Liaison.

Your claim will be assigned to the Disability Manager whose business card is included in this mailing. The Disability Manager will review your claim to ensure all documents have been completed properly. Once your claim is complete, it will be faxed to UnumProvident.

A claims adjuster at Unum will process your claim, which generally takes about two weeks. Your individual circumstance may cause the claim process to take longer. You may check the status of your claim by calling Unum's Customer Service Department toll free at **1-877-851-7637**. You will be notified by letter when Unum makes a decision on your claim advising if you have been approved or denied for disability benefits. If approved, your letter will also provide the expected end date of your disability. Unum will not pay benefits past the end date unless you provide Unum with updated medical information. You must also provide Unum with any other information they request in order to continue your benefits. In the event that your claim is denied, you may file an appeal through Unum.

As a result of your absence, if you have exhausted or will exhaust your leave accruals and are not receiving a payroll check, you will be sent information on how and when to pay your portion of your benefit premiums. **It is your responsibility to pay your portion of your benefit premiums timely so that your benefits will not lapse**. The County will continue to pay its portion of your benefit premiums for up to 180 days in a rolling 12-month period, as long as you are on an approved leave of absence and pay your portion. In the event you terminate employment with Maricopa County, the County will discontinue paying its portion of your benefit premiums as of the last day of your final pay period. However, you will receive a notice giving you the opportunity to continue your medical, dental and healthcare flexible spending account coverage through COBRA.

Maricopa County

Total Compensation

If you receive any type of compensation, including Donation of Leave, you must report this immediately to your Disability Manager or Unum. Most types of compensation offset your disability benefit payment. Failure to report compensation will result in an overpayment for which you will be liable and responsible to repay.

If you have questions about your Short-Term Disability benefit or are having difficulty in getting an issue resolved with Unum, call your Disability Manager at **602-506-1010**. Press Option 2 for Benefits, and then Option 3 for Short-Term Disability.

If it appears that your absence will last longer than 90 days and you are covered under the Arizona State Retirement System (ASRS), please contact your Disability Manager and ask for a Long-Term Disability application and information packet.

Disability Management Phone: 602-506-1010
Press Option 2 for Benefits, then Option 3
Fax: 602-372-8574

Short Term Disability
Employee's Application for Benefits
Policy # 010491

Employer: **Maricopa County** **Division: Employee Health Initiatives 001**

Employee's Name: _____ ☐☐☐-☐☐-☐☐☐☐

Last First Middle Social Security Number

Residence: _____
Street Address City State Zip Code

Date of Birth: _____/_____/_____ ❑ Female ❑ Male ❑ Left-Handed ❑ Right-Handed

Home Telephone #: ( )_____ Work Telephone #: ( )_____

Occupation: _____ Describe your job duties: _____

_____

Is your condition caused by your current occupation? ❑ Yes ❑ No If Yes, explain:_____

If Yes, have you filed a claim for Workers' Compensation? ❑ Yes ❑ No If Yes, date applied: _____/_____/_____

Have you returned to work? ❑ No ❑ Yes Part Time on: _____/_____/_____ Full Time on: _____/_____/_____

If you haven't returned to work, do you expect to? ❑ No ❑ Yes Part Time on: _____/_____/_____ Full Time on: _____/_____/_____

Please provide the full name, specialty, complete address and telephone number of your doctor, and dates of treatment:

_____/_____/_____/ ( ) _____
Full Name Specialty Complete Mailing Address Telephone #.

Treated From: _____/_____/_____ To: _____/_____/_____

Is this the only doctor you are seeing for treatment and care? ❑ Yes ❑ No If No, attach a list of all other doctor's names, addresses, telephone Numbers, specialties, and dates of treatment.

IF YOUR CLAIM IS FOR PREGNANCY, PLEASE PROVIDE THE FOLLOWING:

Date first treated: _____/_____/_____ ❑ Expected or ❑ Actual Delivery Date: _____/_____/_____

Type of Delivery: ❑ Vaginal ❑ Caesarean……Date Scheduled: _____/_____/_____

Last Day Worked: _____/_____/_____ ❑ Expected or ❑ Actual Return to Work Date: _____/_____/_____

IF YOUR CLAIM IS FOR AN ILLNESS, what is the nature of your condition?_____

_____

IF YOUR CLAIM IS FOR AN INJURY, date of injury: _____/_____/_____ Where did injury occur? ❑ Home ❑ Work ❑ Other _____

How did the injury occur? _____ At what time of day? ❑ AM ❑ PM

Date first treated for this condition by a Physician: _____/_____/_____ Last day worked: _____/_____/_____

Do you have a pending lawsuit for this injury? ❑Yes ❑ No

If you were hospitalized or received emergency room treatment for your illness or injury, please complete the following:

Name of Hospital: _____ Telephone #: ( )_____

Complete Address: _____

Date Admitted:____/_____/_____ Date Discharged: _____/_____/_____ Date of Emergency Room Treatment:_____/_____/_____

Have you been treated for this or a similar condition in the past? ❑ Yes ❑ No If Yes, when? _____/_____/_____

Has your doctor advised you to restrict your activities in any way? ❑ Yes ❑ No Explain: _____

_____

I hereby certify that the answers I have provided on this form are full, complete and true.

X_____ _____/_____/_____
Signature Date

Revised 9/1/2003

Be sure to read and sign the Authorization and Agreement Form.

Disability Management Phone: 602-506-1010
Press Option 2 for Benefits, then Option 3
Fax: 602-372-8574

Short Term Disability Employer's Statement Policy # 010491

Employer: **Maricopa County** **Division: Employee Health Initiatives 001**

Employee's Name: _____
Last First Middle

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Employee's Home Telephone #: ( )_____ Home Address: _____

Date of Birth: _____/_____/_____ Department Name: _____ Location: _____

Job Title: _____ ❑ Regular ❑ Part-time Regular Hours scheduled to worked/week: _____

Date of Hire: _____/_____/_____

Current Benefit % Elected: ☐ 40% ☐ 50% ☐ 60% ☐ 70% Effective Date of Current Benefit Election: _____/_____/_____

Date the employee originally enrolled in this plan, if different from Effective Date of Current Benefit Election: _____/_____/_____

Original benefit % elected, if different from Current Benefit % Elected: ☐ 40% ☐ 50% ☐ 60% ☐ 70%

Last Day Worked: _____/_____/_____ Was more than 1/2 day worked? ❑ Yes ❑ No

Date first absent due to medical condition: _____/_____/_____ If recovered, date returned to work: _____/_____/_____

Hourly Rate of pay at the time of disability: $_____ Employee's Work Telephone #: ( )_____

Last Day in Pay Status: _____/_____/_____ (Calculated by counting accruals of *FML/Sick, Donations of Leave, and PTO, if requested)*

Is the employee receiving/entitled to receive any type of income benefits?:

		Frequency of Payment	Dollar Amount	Date Beginning	Date Ending
❑ Yes	❑ No	Workers' Compensation	_____	____/____/_____	____/____/_____
❑ Yes	❑ No	Other	_____	____/____/_____	____/____/_____

(TPA is Pinnacle Risk Management, 7500 N Dreamy Draw, Suite 135, Phoenix, AZ, 85020 (480) 367-2000)

❑ Yes ❑ No Does the employee have employer-sponsored LTD coverage? (If covered by ASRS, answer Yes)

Why did the employee stop working? _____

_____

Is the employee's condition related to his or her occupation? ❑ Yes ❑ No

If YES, has the employee filed a claim for Worker's Compensation? ❑ Yes ❑ No If yes, date applied: _____/____/_____

Date employee assigned to present position: _____/_____/_____

Days worked per week: ❑ Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑ Sat ❑ Sun # of hours/day: _____

Essential Functions & Environments must be attached to this form. (A Personnel Requisition is preferred)

_____ _____ ( )_____ ( )_____
Name of Employee's Supervisor Division/Location Telephone # Fax #

_____ _____ ( )_____ ( )_____
Name of Benefits Representative Completing this Statement Division/Location Telephone # Fax #

X_____ _____/_____/_____
Signature Date

Revised 9/9/2003

Disability Management Phone: 602-506-1010
Press Option 2 for Benefits, then Option 3
Fax: 602-372-8574

Short Term Disability
Attending Physician's Statement
Policy # 10491

Employer: **Maricopa County** **Division: Employee Health Initiatives 001**

Patient's Name:

_____
Last First Middle

Social Security Number

Height _____ Weight _____lbs.

Primary Diagnosis: _____ ICD-9 Code DSM-III- R Code

Secondary Diagnosis: _____ ICD-9 Code DSM-III- R Code

❑ **Pregnancy** Date of LMP: _____/_____/_____ Date First Treated: _____/_____/_____

Delivery Date:_____/_____/_____
❑ Actual ❑ Estimated If Actual delivery date, type of delivery: Vaginal Caesarean

Has patient been released from your care? ❑ Yes ❑ No If No, estimated date of release: _____/_____/_____

❑ **Illness/Injury/Pregnancy Complications** Objective findings: _____

Complications: _____

Subjective Symptoms: _____

Has this patient ever had the same or similar condition: ❑ Yes ❑ No If Yes, what year(s): _____

Describe: _____

Date symptoms first appeared (or date of accident): _____/_____/_____ Is the patient still under your care for this condition? ❑ Yes ❑ No

Date of treatment: FIRST:_____/_____/_____ Next appointment date: _____/_____/_____

Has the patient undergone surgery? ❑ Yes ❑ No If Yes, provide date, procedure and result: _____

CPT-4 Code _____

If No, do you expect surgery to be performed in the future? ❑ Yes ❑ No If Yes, provide date: _____/_____/_____

Type of Surgery:_____ List all medication, frequency and dosage _____

_____

Other types of treatment and frequency: _____

Date first unable to work: _____/_____/_____ Is condition due to injury/sickness arising out of patient's employment? ❑ Yes ❑ No

Patient Status: ❑ Recovered ❑ Improved ❑ Unchanged ❑ Retrogressed

Patient is: ❑ Ambulatory ❑ House Confined ❑ Bed Confined ❑ Hospitalized - From:_____/_____/_____ To:_____/_____/_____

What is the prognosis?_____ When will patient recover: ____/_____/_____

Please describe any restrictions (what your patient SHOULD NOT do): _____

Please describe any limitations (what your patient CANNOT do): _____

Please describe any physical and/or mental impairments: _____

Do you believe your patient is competent to endorse checks and direct the use of the proceeds? ❑ Yes ❑ No

Has the patient been released from your care? ❑ Yes ❑ No
If No, estimated date of release: _____/_____/_____

_____ _____ ❑ Yes ❑ No _____ _____
Name of Attending Physician Degree/Specialty Board Certified Telephone Number Fax Number

_____
Street Address City State Zip Code

_____ _____/_____/_____ _____
Original Signature Date Tax ID No.

Authorization & Agreements

This form authorizes the below-named persons and organizations to release information about your claim to your Employer and to UnumProvident, the claims administrator. The authorization on this form must be given by the person claiming disability benefits (you, the "claimant") or the claimant's legal representative. *This form must be signed by the claimant or the claimant's legal representative in order for benefit payments to be made.*

			–			–				

Print Claimant's Full Name: _____ **Social Security Number**

Employer: MARICOPA COUNTY **Plan: Short Term Disability**

To all physicians and other medical professionals, hospitals and other medical-care institutions and psychiatric-care institutions, and to governmental agencies, insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators:

You are authorized to provide the above-named Employer and the benefit plan and/or claims administrator with information concerning medical care, advice, treatment or supplies provided to the claimant, and any employment-related information regarding the claimant. This information will be used for the purpose of evaluating and administering the claim for benefits. A verbal interview is also authorized. A copy of this authorization shall have the same authority as the original.

I understand that the duration of this authorization is for the term of coverage under the Plan that my claim for disability benefits has been submitted. **I also understand** that I have a right to receive a copy of this authorization upon request.

X_____ _____/_____/_____

Claimant's or Legal Representative's Signature Date

I acknowledge that the Plan includes provisions reserving the right to reduce Plan benefits payable to me by amounts paid or payable to me by other disability program benefits, including but not limited to Social Security Disability and Retirement benefits. I acknowledge the advantage of having the Plan pay my regular benefits until such time as I receive any such additional benefits. I realize that when I receive any additional benefits, an overpayment may occur on my claim.

I agree that I will immediately notify the claims administrator, UnumProvident, when awarded Third Party settlements and that I will pay back to the Plan all amounts of such payments over and above the amounts through which I would be entitled under the Plan provisions.

I also agree that neither the filing of this claim nor the payment of benefits by or on behalf of the Employer under any Sick Pay, Salary Continuance, Short Term Disability or Long-Term Disability plan shall constitute an admission of any liability of or payment thereunder, or a waiver of any of the conditions of any such plan. I further understand that I may be required to participate in one or more Independent Medical Examinations (IMEs) in connection with my claim.

X_____ _____/_____/_____

Claimant's or Legal Representative's Signature Date

CLAIMS ADMINISTERED BY:

UnumProvident
Glendale Customer Care Center
655 N. Central Ave., Suite #800
Glendale, CA 91203
Toll Free Phone No.: 877-851-7637
Toll Free Fax No.: 877-851-7624

Maricopa County

Total Compensation

301 W. Jefferson St, Ste 160
Phoenix, Arizona 85003
Phone: (602) 506-1010
Fax: (602) 372-8574

Notification To Use Short-Term Disability in Lieu of PTO/Vacation

Name:_____ Employee Number:_____

Address:_____ Phone number: _____

You are required to use all of your Family/Medical Leave (FML)/Sick Leave prior to beginning to receive Short-Term Disability payments. Once you have exhausted your FML/Sick Leave, you may elect to use some, all or none of your PTO/Vacation Leave. However, you MUST use available accruals (PTO/Vac and FML/Sick) to cover the 14 day elimination period.

Indicate below if you wish to use any of your PTO/Vacation Leave after the 14-day elimination period:

☐ I do not want to use any of my PTO/Vacation leave

☐ I want to use some or all of my PTO/Vacation leave
Indicate how many hours of PTO/Vacation you wish to use: _____.

IMPORTANT NOTE: If you do not complete this form and give it to your Disability Manager and your Payroll or HR Liaison when you originally file your claim for Short-Term Disability, your PTO/Vacation time will be used before your Short-Term Disability Benefit begins. This will decrease the total number of weeks that the Short-Term Disability Benefit is available to you.

_____ _____
Employee signature Date

Provide a copy of this completed form to your Disability Manager and your Payroll or HR Liaison.